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Injectable Quadrivalent Flu Immunization Vaccine Administration, Assessment and Consent Form (2018-2019)

Name: _____ Birth Date: _____

Does your child (age 6 months or older) have:

Yes No any severe (life threatening) allergy including allergy to eggs or egg products?

Yes No a history of Guillain-Barre Syndrome?

Yes No a previous severe reaction to the flu vaccine?

Yes No a moderate to severe illness today?

Yes No a known problem with the immune system?

Yes No a previous seizure or febrile seizure?

Yes No a previous fainting episode after a medical procedure?

I have read and understand the information given to me, including the Vaccine Information Statement (VIS). I've had a chance to ask questions, which were answered to my satisfaction. I believe that I understand the benefits and risks of taking the flu vaccine, and I request that the vaccine be given to my child. I hereby release all sponsors and businesses associated with the vaccination program from any and all liability associated with administration and potential side effects of the shot.

Parent/Guardian Signature: _____ Date: _____

For Office Use:

Vaccine manufacturer: Sanofi-Pasteur Lot Number: _____ Exp. Date _____

Date of vaccine administration: _____ Temp _____ Grits checked ()

Administered by: _____

Site of administration: right deltoid left deltoid right thigh left thigh